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MAKING SENSE OF INQUIRY SENSEMAKING

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MAKING SENSE OF INQUIRY SENSEMAKING

ABSTRACT

This paper presents an analysis of a report of a Tribunal of Inquiry in order to further our understanding of inquiry team sensemaking. The subject of the paper is the Report of the *Allitt Inquiry* into attacks on children on Ward Four at Grantham and Kesteven Hospital in the UK. Premised on an understanding of the Report as crystallized sensemaking, and sensemaking as a narrative process, the paper illustrates how authorial strategies centred on issues of normalization, observation, and absolution are employed to create a rhetorical and verisimilitudinous artifact. This, it is argued, is accomplished as part of a more general strategy of depoliticizing the disaster event, legitimating social institutions, (especially those connected with the medical profession), ameliorating anxieties by elaborating fantasies of omnipotence and control, and thenceforth acting as a sensitizing narrative archetype.

INTRODUCTION

What can we learn about sensemaking, and especially inquiry team sensemaking, from the reports authored by inquiry teams? In a world in which public inquiry ceremonies (Gephart, 1978; Trice & Beyer, 1984) are a common and important feature of the cultural adjustment stage of critical events (Turner, 1976, 1978), this is a significant but under-researched and under-theorized question. Here it is argued that such reports are rhetorical constructs (Edmonson, 1984; Nelson, Megill, & McCloskey, 1987) designed to elicit verisimilitude attributions from their target audiences (Goodman, 1969; Tyler, 1987; Van Maanen, 1988; Watson, 1995). This is accomplished as part of a broader strategy of depoliticizing disaster events, and legitimating the actions and interests of dominant groups (Kemp, 1985, p.177; Gephart, 1992, p.117). The reports also serve to ameliorate anxieties provoked by the original event by elaborating fantasies of omnipotence and control (Bormann, 1983; Coopey, Keegan, & Emler, 1997; Gabriel, 1991; Lasch, 1978; Zaleznik, 1966), and once published act as sensitizing narrative archetypes (Berger & Luckmann, 1966; Garfinkel, 1967; Gephart, 1993).

Sensemaking refers to those processes of interpretation and meaning production whereby individuals and groups reflect on and interpret phenomena and produce intersubjective accounts (Leiter, 1980; Weick, 1995). It is by means of sensemaking that the social world is enacted, "creating" organizations and their environments (Berger & Luckmann, 1966; Bittner, 1974). Sensemaking is constituted and revealed in our written and spoken descriptions of the world, with "sense" occurring when individuals act as if they share meanings they have jointly and consensually negotiated (Cicourel, 1981; Emerson, 1981; Garfinkel, 1967; Gephart, 1978; Lyman & Scott, 1970). As a matter of fact, however, this illusion of sense being made and shared tends to occur despite an actual lack of agreement, i.e. in processes of sensemaking fundamental inconsistencies between individuals' viewpoints are overlooked, with individuals preferring to assume that they share common perceptions (Gephart, Steier & Lawrence, 1990; Leiter, 1980, p.78; Lynch, 1985). In addition, given that in any social hierarchy some voices are more privileged than others, it may often be more appropriate to describe sense as being imposed by dominant individuals and groups, rather than consensually negotiated by all (Clegg, 1975,

1981).

Most sensemaking research has focused on how people come to understand those events in which they are currently, or have in the past, participated. These studies have greatly expanded our knowledge of how individuals and groups attempt to "structure the unknown" (Waterman, 1990, p.41) by placing stimuli into cognitive frameworks (Starbuck & Milliken, 1988; Ring and Rands, 1989). Further, analyses of different types of sensemaking and sensemaking situation, such as the making of government policy (Janis, 1972), newcomer socialization (Louis, 1980), policy making (Feldman, 1989), and decision-making in life-threatening contexts (Weick, 1993) have clarified the extent to which sensemaking involves creative authoring on the part of individuals and groups, who construct meaning from puzzling and troubling data (Shotter, 1993; Weick, 1995). What is more, we know that peoples` sensemaking activities are prone to distortions resulting from incomplete or inaccurate information processing (Dearborn & Simon, 1958; Einhorn & Hogarth, 1986; Hedberg, 1981; Kahneman, et al., 1982; Levitt & March, 1988; Slovic, et al., 1977;) and the operation of the ego-defenses (Argyris, 1982; Brown, 1997; Laughlin, 1970).

Perhaps the most useful way of understanding sensemaking is as a narrative process (Bruner, 1990; Fisher, 1984; MacIntyre, 1981; Weick, 1995). The idea that sensemaking tends to take a narrative form has its origins in suggestions that "man is in his actions and practice, as well as his fictions, essentially a story-telling animal" (MacIntyre, 1981, p.201), and thus appropriately described as *homo narrans* (Fisher, 1984, p.6; see also Barthes, 1977; Bateson, 1979; Burke, 1968; Bruner, 1990). This insight has been deployed in an organizational context by Boje (1995, p.1000), who has referred to organizations as collective storytelling systems "in which the performance of stories is a key part of members` sensemaking and a means to allow them to supplement individual memories with institutional memory", while Bruner (1990, p.112) has discussed the role that stories play in helping us achieve "coherence, livability and adequacy". Narratives have variously been described as "a tool or program for making sense of events" (Gephart, 1991, p.37), "a blueprint that can be used to predict future organizational behavior" (Martin, 1992, p.287), and the means by which individuals organize their experiences (March & Sevón, 1984; Boyce, 1990, 1995; Weick, 1995). There is a reasonable consensus that

sensemaking is accomplished through narratives which "make the unexpected expectable" (Robinson, 1981, p.60), allow us to comprehend causal relationships such that they can be "predicted, understood, and possibly controlled" (Sutton & Kahn, 1987), and which assist organizational "participants [to] map their reality" (Wilkins & Thompson, 1991, p.20).

In most instances of sensemaking that have been researched sensemaking is both "triggered by a failure to confirm one's self" and "occurs in the service of maintaining a consistent positive self-conception" (Weick, 1995, p.23; see also, Bruner, 1990; Ring & Van de Ven, 1989). As Coopey, Keegan and Emler (1997, p.312) have recently stated:

"Faced with events that disrupt normal expectations and, hence, the efficacy of established patterns of meaning and associated behaviour, individuals attempt to make sense of ambiguous stimuli in ways that respond to their own identity needs. They are able to draw creatively on their memory - especially their personal experience - in composing a story that begins to make sense of what is happening while potentially enhancing their feelings of self-esteem and self-efficacy. The story is a sufficiently plausible account of `what is happening out there` that it can serve as a landscape within which they and others might be able to make commitments and to act in ways that serve to establish new meanings and new patterns of behaviour".

Inquiry sensemaking is unusual because inquiry team members have not usually participated in the occurrences they are subsequently tasked with investigating, and thus their identities are not directly at stake in the proceedings. There is, of course, a sense in which in the conduct of their inquiry and interpretation of evidence members of inquiry team's are constituting themselves as subjects in ways prompted by needs for self-esteem (Banaji & Prentice, 1994; Ring & Van de Ven, 1989), but these processes are one step removed from the actual occurrences being inquired into, and this separation of self from the object of sensemaking might reasonably be expected to lessen the extent of their personal stake in the details of the account they offer.

Public inquiries are ceremonials that assemble explanatory accounts of the events under scrutiny from the statements of witnesses (Gephart, 1984, 1993). They represent the "longer term organizational responses" to crises (Shrivastva et al, 1988, p.292) through which considerable institutional and organizational learning occurs (Turner, 1976, 1988). While some sensemaking research has drawn on the findings of inquiries (Douglas, 1986; Gephart, 1992, 1994; Gephart,

Steier, & Lawrence, 1990; Kemp, 1985; Turner, 1976, 1978), these have tended to focus on the events described rather than on the texts they have produced. This is unfortunate because public inquiries are particularly interesting multilevel micro-macro events in "which micro-level sensemaking practices produce the macro social order as a set of representative meanings tracked across social settings" (Gephart, Steier, & Lawrence, 1990, p.44-45; Cicourel & Knorr-Cetina, 1981). A detailed focus on such texts may thus assist us in theorizing multiple levels of sensemaking.

Public inquiries and the reports they produce are centrally concerned with establishing the legitimacy of organizations and institutions, where legitimacy is understood as "a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions" (Suchman, 1995, p.574; see also DiMaggio & Powell, 1991; Meyer & Scott, 1983). The sorts of major problems they probe produce legitimation deficits for the state apparatus (Habermas, 1973, pp.47, 70) by undermining myths of state and organizational control (Gusfield, 1981), resulting in a threatened failure of the legitimizing system to maintain "the requisite level of mass loyalty" (Habermas, 1973, p.46). Public inquiries constitute societal level "last resort" ceremonies (Emerson, 1981) which re-establish dominant myths by offering acceptable interpretations for the events, and hence re-establish the legitimacy of social institutions (Gephart, Steier, & Lawrence, 1990, p.29; see also Meyer & Rowan, 1977; Pfeffer, 1981; Suchman, 1995). Public inquiries, and the reports they produce, may thus be described as exercises in power, where power is defined as the capacity to extend hegemonic reach by suppressing or overwhelming competing accounts such that one's own interpretation dominates (Barry & Elmes, 1997; Boje, 1995; Molotch & Lester, 1975).

The focal issue considered here is how inquiry reports support the legitimacy of social institutions and extend the hegemony of prevailing system-supportive ideologies. The argument pursued is that such reports constitute rhetorical products designed to persuade us to accept certain non-irrefragable ideas (Aristotle, 1991; Atkinson, 1990; Czarniawska-Joerges, 1995; Edmonson, 1984; McCloskey, 1985; Nelson, Megill, & McCloskey, 1987). To succeed, inquiry reports must strike their intended audiences as truthful (Barnes, 1991), plausible and

authoritative (Van Mannen, 1988), or verisimilitudinous (Bruner, 1990, p.61; Denzin & Lincoln, 1994). For an audience to experience a report as verisimilitudinous requires it to conform to that audience's convention-governed views regarding what is believable and what is not (Goodman, 1969, 1970, 1983). These conventions, drawn from the macro-social and historical context in which the report is authored, specify what constitutes a plausible storyline in general and an authoritative report in particular. It is vital to note that scholarly theories of sensemaking are also affected by conventionalized notions regarding what constitutes reasonable and adequate description of human social behaviour. While the relationship between specialist theory and accepted social convention is one of dialectical interaction, and this limits the extent of their indexical complementarity, consonance rather than conflict between their prescriptions, it is argued, is more likely in the modal case. In short, in this instance we would expect to be able to unproblematically analyze the contents of any public inquiry report using current theories of sensemaking because both will conform to broader culturally stereotyped conventions.

This paper focuses on a single instance of inquiry sensemaking, namely the *The Allitt Inquiry*. Premised on an understanding of the Report as crystallized sensemaking, and sensemaking as a narrative process, it illustrates the arbitrary choices made by the inquiry team in coming to an understanding of events. It then argues that the representational strategies employed by the authors have three broader social implications. First, it is argued that the Report seeks an allocation of responsibility and blame (Douglas, 1985, p.56; Gephart, 1993, p.1474/5), which de-emphasizes the extent to which medicine as a profession and the consultants in particular are culpable. Second, the Report functions to reduce anxiety both within the medical profession and within society generally by offering an explanation which promotes fantasies of comprehension and control (Bormann; 1983; Coopey, Keegan, & Emler, 1997; Gabriel, 1991; Lasch, 1978; Zaleznik, 1966). Finally, the Report serves as a sensitizing narrative archetype that should make discernment of similar-type patterns easier in the future (Berger & Luckmann, 1966; Garfinkel, 1967; Gephart, 1993).

METHODOLOGY AND TEXT

The analysis offered here is of the text of *The Allitt Report* ("AR"), which represents the inquiry team's collective efforts to make sense of the events described to them by witnesses in oral and

written submissions. The decision to base a sensemaking analysis on a report was influenced by a growing body of text-based research (see, for example, Czarniawska-Joerges & Guillet de Monthoux, 1994; Gephart, 1992, 1993; Grey, 1996; Gowler and Legge, 1991; Weick, 1993). While some authors such as Gephart and Weick admirably demonstrate that sensemaking processes can be investigated using a wholly textual data set, they have tended either to treat the texts they use as more or less true accounts of the events they describe (Weick, 1993) and/or represent their analyses as quasi-scientifically derived (Gephart, 1993). In contrast, here we embrace the view that *The Allitt Report* is a deliberately conceived artifact that has resulted from authorial strategies of selection and omission of material, and which makes use of rhetorical devices such as example and metaphor to present *an* (not the only) understanding of events (Edmondson, 1984; Nelson, Megill & McCloskey, 1987; Czarniawska-Joerges, 1997). Moreover, the focus of the paper is on the text produced by the inquiry team, rather than the putative actions and motivations of those the text describes, i.e. definite and immediate evidence of the inquiry team's sensemaking activities, albeit a trace of them rather than the activities themselves.

It is interesting to note that the recognition that sensemaking is a form of narrativization has not led scholars in organization studies to a strong interest in written texts as "crystallized" sensemaking efforts. Part of the reason for this may be uncertainty regarding appropriate means for their analysis, and the difficulty of representing such analyses as rigorous and accurate (Gephart, 1993, p.1466). The guiding assumptions employed here suggest that authors embed interpretations in their texts (Knorr-Cetina, 1981), that texts are derived from and acquire meaning in their relation to other texts or discourses (Culler, 1982, p.33, 103), and that such texts incorporate and reflect particular sets of institutional and ideological circumstances, i.e. are power effects (Foucault, 1977). In this research the text of the Report was constantly read and re-read by the researcher who simultaneously compiled lists of what seemed to be core themes (Glaser & Strauss, 1967; Strauss, 1987). These themes were generated, and then linked together, subsumed, modified, and discarded in largely idiosyncratic processes of refinement and embellishment (Martin & Turner, 1986; Strauss, 1987; Turner, 1981, 1983).

The result was the identification/fabrication of three broad and interrelated categories here

labelled "normalizing and demonizing", "observing and discerning", and "blaming and absolving". The argument pursued is that the Report intentionally represents Allitt as outwardly normal (normalizing rather than demonizing), and that this is important because it subsequently permits the depiction of the general failure to detect Allitt's activities sooner (observing without discerning) as plausible, and that this strategem is employed to mitigate criticism of the doctors, nurses and administrators who worked with her (absolving more than blaming). In summary, the construction of a normalizing biographical narrative, and the account of how individuals observed events without discerning a pattern, are authorial strategies which have as their aim the construction of verisimilitudinous text, the absolution of Allitt's colleagues, and the legitimization of the medical profession.

Rather than attempt to disguise the extent to which the analysis presented here is a personal one, there is instead an explicit acknowledgement of what is inevitable (but still rarely asserted): interpretive research is not a quest for ultimate truth but for a plausible, authoritative, verisimilitudinous, and interesting analysis that enriches our understanding of social phenomena (Tyler, 1987; Van Mannen, 1988; Denzin & Lincoln, 1994; Nelson, 1995; Czarniawska-Joerges, 1997). In the authoring of interpretive case-based research of this type there is a reasonable requirement that the writer be reflexive about the representations s/he has produced (Chia, 1996, p.51; Knights, 1992, p.515). Here, it is explicitly acknowledged that this paper is an artful product designed not just to inform but to persuade, and that the illusion of objectivity is no more than an authorial strategy, i.e. illusory (Atkinson, 1990; Watson, 1994, 1995). That an acknowledgement to this effect has now become a condition (at least in certain European journals) for a scholarly audience to receive interpretive work as authentic and credible (Jeffcutt, 1994), is an interesting symptom of how conventions governing the representation of qualitative research have altered in recent years.

The Allitt Inquiry was an independent Tribunal of Inquiry initiated in May 1993 by the United Kingdom's Secretary of State for Health to "enquire into the circumstances leading to the deaths of four children and injuries to nine others on Ward Four at GKGH [Grantham and Kesteven General Hospital] during the months of February to April 1991 (inclusive)" (AR 1994, p.6). The team, which consisted of a former senior civil servant, the director of quality for the childrens'

hospitals in Manchester, and a retired professor of clinical neurology, met on 35 occasions between the 7th of June 1993 and the 26th of January 1994. During this time they interviewed 94 witnesses, considered the written submissions of one witness not then in the UK and ten "interested bodies", and reviewed "many thousands of pages of documentary evidence" (AR, Appendix 2). The Report itself is composed of 131 pages of text and four appendices, and has four major sections: a biography of Allitt up until the time she was recruited as an enrolled nurse, an overview of the attacks on the children, a description of the doctors' and nurses' responses to the attacks, and a miscellaneous collection of "general themes" which provide some insight into issues such as equipment and staffing on the ward where the attacks took place. Each paragraph of the Report is conveniently numbered, and it is this nomenclature that is used to identify passages from the Report itself in this paper.

In brief, the Report narrates the story of how the child deaths and collapses occurred, and the doctors' and nurses' responses to these events. The Report relates how, in each instance, it seemed to the clinical staff that what had happened, while unusual, could nevertheless be explained on the basis of each child's medical history. Over time, and as more children collapsed and died unexpectedly, the bewilderment of the doctors and nurses grew into alarm. Post mortem examinations were conducted on the children who died and tests to try to determine the cause of their collapse were carried out on each of the children who survived. Most of these tests proved negative. On 12th April 1991, however, a blood test showed that a child had been wrongly injected with insulin. The possibility that this had been done accidentally was, in time, eliminated, and together with further emergencies on the Ward, fostered the suspicion that someone was deliberately harming the children. On 30th April 1991, the police were called to the Ward to investigate. After several months they identified an Enrolled Nurse named Beverly Allitt as the likely culprit. In May 1993 Beverly Allitt was convicted of four murders, three attempted murders and of causing grievous bodily harm to six other children.

DECONSTRUCTING THE TEXT

This section has three broad and interrelated objectives. First, it seeks to illustrate the principal macro-argument of the *Allitt Report*: no one noticed that Allitt was unusual because there was nothing unusual to notice; this accounts for her activities being undetected and unsuspected for

so long, and (together with certain managerial aspects) partially accounts for the clinical team's failure to detect a pattern of child collapses; and, these are factors that mitigate criticism of those who educated and worked with Allitt. Second, it attempts to outline an alternative plotline from the same data employed by the authors of the Report: While Allitt manifested signs of abnormality these were simply not noticed or not attributed significance; that it was possible to discern a pattern of child collapses and to take remedial action at a much earlier stage than in fact occurred; and, that the failures that are catalogued in the Report could be reinterpreted as an indictment of the medical professionals directly involved. The three moments of the Report's and our alternative arguments are summarized in figure 1, which contrasts the normalizing-observing-absolving reasoning of the Report with our alternative demonizing-discerning-blaming frame. Third, it deploys organizational theories of sensemaking to analyze the narrative related in the Report. This is conducted to exemplify our prior stated assumption that to be successful, i.e. to elicit a verisimilitude attribution, the text must be susceptible to an interpretation in terms of prevailing specialist theory. There are two important points to note here: (1) if a scholarly management audience were to fail to receive the text as plausible and authoritative then this would severely limit the success of the Report as a vehicle for the absolution of individual clinicians and legitimation of the medical profession more generally; and (2) it is the narrative encoded in the Report that is being analyzed, not the events themselves, to which we have no privileged access.

.....
Figure 1 about here please
.....

Normalizing and Demonizing

The first major section of the Report consists of a biography of Allitt. The Inquiry was, in part, spurred by suggestions in the media that Allitt suffered from a personality disorder known as Munchausen Syndrome, that this should have been diagnosed, and that on this basis Allitt should have been refused entry to the nursing profession (AR 2.1.3). Munchausen Syndrome is a phrase introduced in 1951 to refer to those people who travel from hospital to hospital with stories of

medical disorder, often severe and dramatic, and usually supported by pathological evidence (which may be falsified). The Inquiry's attempt to account for the "extraordinary" fact that someone who later turned out to be a mass murderer was recruited and trained into the nursing profession "without anyone realizing the danger she presented" (AR 2.1.1) centres on its attempts to portray Allitt as insufficiently unusual to evoke concern in those who knew her. Given the ambiguous information available, the inquiry team made a choice, though perhaps not one they were fully conscious of, to understand and represent Allitt in a particular way. Faced with either normalizing or demonizing Allitt's apparent behaviour, the inquiry team made sense of the information available to them to construct a narrative which depicted her as apparently free from disorder. The Report's account of Allitt's educational and training biography can be fairly succinctly summarized:

While at school Allitt used to babysit regularly for families in her village, and no complaints regarding her were discovered by the Inquiry. She chose 'O' levels which pointed her towards a caring career. Teaching staff "remembered her well, but could not recall any significant incidents in which she was involved" (AR 2.2.2). Indeed, they described her as approachable, as getting on well with classmates, as willing to help out with events at the school in the evening, as relating well to people of different ages, as not being unkind, and showing no signs of ill-temper. Teachers did note that she was "often seen around the school wearing a bandage or with her arm in a sling. She was known to be accident-prone and suffered from a succession of minor injuries" (AR 2.2.4). This said, she was not absent for long periods, and always had a plausible explanation for her injuries.

Having left school, Allitt spent two years on a pre-nursing course at Grantham College. The Report notes that there was now evidence of personality change, with Allitt becoming more "shy, quiet and somewhat introverted" (AR 2.3.2), and that she experienced difficulties working with the elderly and mentally handicapped. Despite this, "By the end of the first year, her tutors were pleased with her progress and felt that she had the potential to become a good nurse" (AR 2.3.3). Reviewing her second year record, it was evident that Allitt's "injuries and illnesses became more frequent", and that she "appeared to be using them to draw attention to herself". Indeed, while she had missed only 11 days tuition in her first year, she missed 52 days out of a possible 180 in the second (AR 2.3.5).

Allitt then applied to South Lincolnshire School of Nursing (SLSN) with a view to training for two years to become an enrolled nurse. She provided references from her school and a local businessman. No reference was provided by her pre-nursing course tutors, and this "unusual" occurrence meant that her "recent sickness was not brought to the attention of her interviewers at the School of Nursing" (AR 2.4.3). Allitt's poor attendance record continued, and she missed 126 days during her 110 week course (AR 2.5.4). On just one occasion was she interviewed by the Senior Tutor regarding her absences, and "Allitt was able to convince her that her absences were for genuine and various reasons" (AR 2.5.6). "Allitt passed her exams to become an enrolled nurse in December 1990, but due to her sickness she had not completed the required number of days' experience on the wards. It was therefore necessary for her to undertake a further ward placement before qualifying as an enrolled nurse" (AR 2.5.9). She was sent to the childrens' ward, Ward Four, at GKGH.

The inquiry team's attempts to normalize Allitt's personality and behaviour focus on those three categories of activity that could be identified as possible evidence of dysfunctionality: (1) her

tendency to wear her arm in a sling and reputation as accident prone; (2) personality change from someone who was approachable and related well to people, into an individual who was shy, quiet, and who had some difficulties dealing with the elderly and handicapped; and (3) her poor attendance record at Grantham College and South Lincolnshire School of Nursing. In each instance arguments are made which suggest that Allitt's behaviour was within the boundaries of normal expectations.

Witnesses to the Inquiry asserted that Allitt, while at school, and Grantham College, was often seen with a bandage or wearing her arm in a sling. Such behaviour in a school context is normalized using three arguments: (1) that she was not absent for long periods; (2) that she always had a plausible explanation for her injuries; and (3) that "She was not the only pupil at the school who was accident-prone, nor the only one to enjoy the attention attracted by a bandage" (AR 2.2.5). Indeed, such a tendency is described as "very common" (AR 2.2.6). Once at Grantham College Allitt's injuries and illnesses not only became more frequent, but "She often showed her injuries to her tutors, and appeared to be using them to draw attention to herself" (AR 2.3.4). Again, however, such behaviour is represented as unexceptional, as "Grantham College had seen numerous teenagers who exhibited this kind of behaviour and grew out of it" (AR 2.3.4). The normalization of Allitt's behaviour allows the Report both to account for the fact that while at school and college "No one had any suspicion that they [Allitt's injuries] might not be accidental" (AR 2.2.5, 2.3.4), and to absolve these institutions, and their personnel, of any culpable oversight.

From evidence given in testimony to the Inquiry, the Report detected a personality change in Allitt which manifested itself in the form of increased introversion and a lack of confidence. This is partly accounted for by the Report in terms of her having moved from a school in a "small village" to "the relatively large town of Grantham", and by her academic abilities being stretched by the course she took (AR 2.3.2). Moreover, while at South Lincolnshire School of Nursing, "Her tutors could not recall her being involved in any remarkable incidents. She was an average pupil..." (AR 2.5.1), leading the Inquiry team to conclude that "Once again, the picture we find is of an ordinary girl, who showed no signs of abnormal behaviour or disordered personality" (AR 2.5.1). While Allitt's level of absence is described as "remarkable" (AR 2.5.4) and "unusual"

(2.5.5), it is presented in the context that "in each year there were a handful of students with high sickness rates" (AR 2.5.5). The Inquiry was adamant that "there was no reason at that time to link Allitt's own health record with the danger she later presented to the children on Ward Four" (AR 2.4.5). The consistent storyline pursued by the Report is that "there was no sign in her [Allitt's] general behaviour of what was to come" (AR 2.3.6), and that while errors of judgement and institutional procedure were made, "even had everything been done correctly, it is unlikely that Allitt would have been eliminated from the nursing profession" (AR 2.6.17).

That the inquiry team sought to make sense of the information available to it in this way, was not pre-determined. For example, an alternative plotline, depicting Allitt as deviating considerably from the norm, could have been constructed from the available information. Such a narrative would have required the inquiry team to reflect that Allitt's tutors' protestations that she was in no way extraordinary have to be understood in the context of her recent conviction for mass murder. Deceit, including self-deceit, may well have played a role here (Camus, 1956; Fingarette, 1969; Sartre, 1958). It might have emphasized that attempts to gain attention through feigned injury in such regular and sustained ways, while certainly "not an indication of secret murderous intent" (AR 2.2.6), are far from the defining characteristic of student nurse populations that the Report sometimes seems to imply (AR 2.2.5, 2.2.6, 2.3.4). Such a narrative could also have reinterpreted the Report on Allitt made by the Head of Department at Grantham College at the end of her second year as a missed opportunity for investigating Allitt's case. The Head of Department wrote: "Clearly Beverly has had a most unsettled year. She may wish to discuss her future when College reconvenes in September" (AR 2.3.5). No action was taken. A demonizing narrative may have made more of the fact that, during her two years at South Lincolnshire School of Nursing, Allitt is known to have voluntarily attended the Occupational Health Department on fifteen occasions, and the Accident and Emergency Department on at least ten occasions (AR 2.5.8). Finally, in December 1990 Allitt was interviewed in a general recruitment round for GKGH, but signally "failed to meet the required standard", not least because "She showed little interest and very little understanding of how her role would change when she qualified" (AR 2.6.2). This fact is noted in the Report without comment, but could surely have been employed to bolster a storyline that portrayed Allitt as an unusual case, and even used as an argument that she should have been disqualified from the nursing profession.

The argument being made here is not that Allitt was, or was not, evidently abnormal. What is contested is that the Report's insistence that no one noticed that Allitt was unusual because there was nothing unusual about her to notice is the only plausible interpretation of the available evidence. An alternate plotline might read: while Allitt manifested signs of abnormality these were simply not noticed or, if noticed, not attributed significance. The point is that the inquiry team deliberately made sense of ambiguous and sometimes contradictory information to construct one sort of narrative (normalizing) rather than another (demonizing), and that this represented a contestable choice, an invention not a discovery. A similar argument has been made by historians such as White, Carr, and Mandelbaum, all of whom suggest that in the writing of historical narratives authors make choices not dictated by the empirical evidence, and that therefore many different narratives may be constructed out of the same material. Evidently, inquiry sensemaking is a craft activity (Watson, 1995) and involves the skills of the *bricoleur* (Weick, 1995) not the deductive logic of the laboratory chemist (see, for example, Watson, 1994; Czarniawska-Joerges, 1997).

Observing and Discerning

The Report devotes approximately fifty pages to an attempt to make sense of how Allitt attacked the children and the doctors' and nurses' responses to these events. Four broad phases of sensemaking activity are implicit in the narrative the Report constructs: (1) the observation of salient occurrences without the discernment of a pattern; (2) the discernment of a pattern accompanied by the imposition of standard explanations; (3) the problematization of the pattern without accompanying action; and finally (4) action based on an understanding of events as actually or potentially problematic. In order to facilitate analysis a much abbreviated version of this part of the Report's narrative has here been pieced together:

GKGH was a "poorly endowed" hospital "on the borderline of viability" (AR 7.3). Ward Four had twenty beds available for children requiring medical or surgical treatment. Children requiring highly specialized treatment or intensive care were transferred to other better equipped hospitals, but this was not a frequent occurrence. The ward was staffed by two Paediatric Consultants (Dr. Nanayakkara and Dr. Porter), and two Senior House Officers on six month placements. Until a third Senior House Officer was appointed on 25.3.91, all four doctors were on call all day and on alternate nights and weekends. The nursing establishment should have consisted of 10.66 full time equivalent nurses, but in January there were 8.86, in February 9.57 and in March 9.30. The Report cites evidence that somewhere between 20.4 and 24 full time equivalent nurses would be appropriate for a unit such as Ward Four. The ward nursing staff were led by a Ward Sister (Sister Barker), who reported to the Clinical Service Manager (Mrs Onions) with broad responsibilities not just for Ward Four but Gynaecology and Midwifery

Services. Mrs Onions reported to an Assistant General Manager (Miss Newton) who in turn reported to the Unit General Manager (Mr Gibson). Between 1986 and 1989 no child died on Ward Four, and the two deaths that occurred in 1990 were, given the serious conditions of the children, not unexpected (AR 4.1.3).

19.2.91 When Allitt's training had come to an end Mrs Onions, the Clinical Service Manager, specifically created an enrolled nurse post for her on Ward 4, and Allitt began work on this date.

23.2.91 Death of baby Liam Taylor. The doctor in charge, Dr. Nanayakkara was "puzzled" by the death and requested that a paediatric pathologist conduct an autopsy. His request was turned down, and a nonpaediatric specialist, Dr. Marshall, undertook the examination. Dr. Marshall was unable to account for the death, describing its cause as "a medical mystery".

5.3.91 Death of Timothy Hardwick. Dr. Nanayakkara was again the consultant in charge, and the autopsy was again conducted by Dr. Marshall. The child's death was as unexpected as the first, and somewhat curiously was attributed by Dr. Marshall to "status epilepticus" even though the nurses in attendance stated that Timothy "had not been having fits at the time of his collapse" (AR 3.3.3).

10.3.91 Kayley Desmond collapsed twice and was transferred to Queen's Medical Centre (QMC). While Dr Nanayakarra wrote that he was "unclear" (AR 3.4.3) what had caused Kayley's collapses, they were thought likely to have been "caused by the inhalation of vomit" (AR 4.4.1). An x-ray taken after the second attack at GKGH, and another taken at QMC, were not regarded as revealing anything suspicious.

23/24/28.3.91 Paul Crampton suffered three hypoglycaemic episodes before being transferred to QMC. The consultant in charge, Dr. Porter, "could not understand why his blood sugar kept dropping so dramatically" (AR 3.5.4), and suspected that he might have a pancreatic tumour. To test his hypothesis Dr. Porter sent a sample of Paul's blood to two laboratories equipped to measure blood insulin levels (which requires a sophisticated hormone assay).

30.3.91 Bradley Gibson collapsed and was transferred to QMC. A blood sample taken an hour after his heart had stopped was tested at GKGH, and the results reported on 2.4.91 showed that he had well above the normal range of potassium. Neither Dr. Porter nor the doctors at QMC could explain the finding. Seven unusual and unexpected episodes of child collapse had now occurred within a period of about four weeks, and Dr. Porter felt "compelled... to list for his personal recollection the collapses which had taken place" (AR 4.6.4).

31.3.91 Yik Hung (Henry) Chan collapsed twice and was transferred to QMC. The doctors tentatively concluded that he had suffered convulsions even though "the experienced nurses who attended Henry did not believe that what they had seen was a typical febrile convulsion" (AR 4.7.2). An x-ray taken at QMC did not arouse any suspicions. Following this case the Night Services Manager wrote a letter to the nurse manager pointing out that there had now been seven cardiac arrests during the last three months (there had been none in the last three years), and expressed concerns about staffing and equipment.

5.4.91 Death of Becky Philips at home, having been discharged from GKGH the day before. The death was diagnosed as Sudden Infant Death Syndrome (SIDS), though Becky's death was not sudden, and the diagnosis seems to have been made "just because no medical explanation could be found" (AR 4.8.3). Becky had been treated on Ward Four on a regular basis since her birth, many nurses "saw her looking well the day before she died, and all heard about her death" (AR 4.8.2).

7.4.91 Katie Philips collapsed and was transferred to Nottingham City Hospital (NCH). Katie had been brought in for observation after her sister had died as a precaution. Having been transferred To NCH she recovered, the discharge letter concluding that "Despite extensive investigations, we do not have a reason for Katie to be so unwell at the same time as her sister" (AR 3.9.2). A series of x-ray films taken at the time at GKGH gave Dr. Nanayakarra no cause for concern.

The Report makes it clear that while there was no atmosphere of crisis, staff were becoming "worried" by events: "The nurses and doctors on the ward began to discuss informally among themselves what might be causing babies

and children on the ward to become so ill" (AR 4.9.9). Several staff discussed the possibility of an infection on the ward, but no "steps were taken to investigate this possibility" (AR 4.9.9).

9.4.91 Michael Davidson collapsed as a junior house officer administered an antibiotic which Allitt had helped to prepare. Dr. Nanayakkara, who was on the ward when it happened, diagnosed carpopedal spasm (a sort of fit) as a result of overbreathing, and this diagnosis was accepted at the time by the surgeons and anaesthetists in charge. The junior house officer who was giving the injection at the time, however, told the inquiry "that what she observed was not, in her judgment, carpopedal spasm" (AR 4.10.2). Even though no association between the injection and Michael's collapse was made at the time, according to South Lincolnshire Health Authority Policy, the remaining contents of the syringe should have been retained for analysis. This was not done.

12.4.91 Dr Porter was advised by telephone of the results of the insulin assay on the sample of Paul Crampton's blood taken during his third hypoglycaemic episode. The results showed that Paul's blood contained insulin which had been administered by injection. Having received the information Dr Porter "remained uncertain" (4.11.2). He phoned the QMC (where Paul was now being treated). The specialist treating Paul was on holiday and Dr Porter spoke to a Paediatric Registrar on call. No firm advice was forthcoming. Dr Porter then waited several days to inform other members of staff on the Ward. In these conversations, uncertainty regarding what the result meant, rather than its possible implications, seems to have dominated. The staff thought it possible that Paul had been given accidentally the dose of insulin intended for someone else, and attempts were made to investigate this. Meanwhile Dr. Porter sought to check "the significance of the results in the medical library" (AR 4.11.7). The information did not provoke any reaction or realization in Dr. Nanayakkara.

13.4.91 Christopher Peasgood collapsed twice, and was transferred to QMC. Two possible explanations for Christopher's collapse were explored. First, it was thought he might have inhaled some milk and choked. Alternatively, it was possible that his existing breathing problems had deteriorated to a point where he could not maintain the proper level of oxygen in his blood. But tests of his oxygen and carbon dioxide levels did not support this.

14/16.4.91 Christopher King collapsed four times, and was transferred to QMC. It was initially thought that these episodes were caused by him inhaling his own vomit, but tests and x-rays showed that that this was not the case. Neither staff at GKGH nor QMC found any medical explanation for his collapses (AR 3.12.3).

16.4.91 Dr Porter left for the Annual Conference of the British Paediatric Association (BPA). He returned on the 17th allowing Dr Nanayakkara to attend. While the inquiry found it "odd" that the consultants should leave their unit in the midst of a "mounting crisis" they assert that "But of course the real problem is that they had not fully recognized the magnitude of the crisis" (AR 4.14.1). While at the conference Dr Porter pondered whether video recording equipment could be used "to see whether someone was indeed attacking children on Ward Four" (AR 4.14.2).

18.4.91 Patrick Elstone collapsed twice, and was transferred to QMC. Dr. Porter attended the first of these, and a locum standing in for Dr. Nanayakarra, the second. No medical explanation for these collapses was discovered (AR 3.13.2). Also on this day, Mrs. Onions informed Dr. Porter that Paul Crampton could not have been given insulin accidentally.

19-22.4.91 By now Dr. Porter had overcome his doubts about the interpretation of the results of the tests on Paul Crampton's blood, and believed that someone was deliberately harming patients on Ward Four. Dr. Porter and Dr. Nanayakkara had a telephone conversation on the evening of 19.4.91 in which Dr. Porter expressed his concerns, but Dr. Nanayakkara was not convinced. The Report notes that the conversation resulted in "no definite conclusion" (AR 4.16.6). Dr. Porter telephoned Mrs. Onions the same evening, and asked her to arrange the installation of video equipment. She told him she did not have authority to do this. Dr. Porter then phoned the Paediatric Registrar at QMC and suggested they measure the level of insulin in Patrick Elstone's blood. The general manager (Mr. Gibson) was informed of Dr. Porter's concerns, but his response was not supportive. According to Mr. Gibson Dr. Porter had acquired a reputation for "fanciful ideas", by which the inquiry "understood him to mean a tendency to raise alarms which were not justified in the event" (AR 4.16.5).

On 20.4.91 the deputy manager, (Mr. Jackson), phoned Mrs. Onions to say that no action would be taken unless she and Dr. Nanayakkara shared Dr. Porter's view. Neither was convinced that anything criminal was going on. Dr. Porter "was becoming increasingly worried, but he did not feel able to call the police himself" (AR 4.16.8). He began to draw up a list of similarities between the various children whose conditions had deteriorated unexpectedly on Ward Four. On 22.4.91 Mrs. Onions informed her superior, Miss. Newton, of events. Miss. Newton thought Dr. Porter to be "a bit unpredictable", and in taking no action, "was clearly influenced by the fact that Mrs. Onions did not believe that anyone could have injected Paul Crampton with insulin deliberately, and that Dr. Nanayakkara apparently did not share Dr Porter's concern" (AR 4.16.9). Later on 22.4.91, Dr. Porter, Dr. Nanayakkara and Mrs. Onions met to discuss matters. Dr Porter was unable to persuade his colleagues of his view. Dr Nanayakkara said he would carry out an audit of the notes of the children involved, but this was never completed. Following the meeting, Dr. Nanayakkara wrote a long letter to Mr. Gibson making the case for more equipment. The letter made it clear that there had been a "most unusual and unexplained spate of emergencies" (AR 4.16.12) but that "he himself did not believe that this [foul play] was the explanation" (AR 4.16.11).

22.4.91 Claire Peck collapsed twice, and died following the second collapse. Her death certificate recorded that she died from "status asthmatics", a "very rare" cause of death for children in hospital (AR 4.17.1). When Claire died Dr. Porter asked Sister Barker to retain Claire's infusion fluids for testing, and discussed the possibility that someone was harming the children deliberately.

23-30.4.91 Mrs Onions and Mrs Barker continued to check to make sure that accidental administration of insulin to Paul Crampton had not occurred. A letter written by Mrs. Onions to Miss. Newton on 24.4.91 indicates that she still had no suspicion as to the cause of the recent emergencies, but expressed her belief that additional resources were required on Ward Four. Miss. Newton's reply "can only be described as a cold rebuff" which does little more than "criticize... Mrs Onions for not providing a more detailed analysis and producing solutions herself" (AR 4.18.4). According to the Report "...it appears that everyone involved was waiting for someone else to do something" (AR 4.18.5). On 29.4.91 Professor Sir David Hull at QMC called a meeting at which the doctors who had treated transferred patients from GKGH discussed the possibility that some "extrinsic factor" was responsible for the childrens' unexpected clinical courses (AR 5.13.22). Sir David phoned Dr. Porter the same day urging him "to go direct to senior management and ask them to call the police" (AR 4.18.6). Dr. Porter did this, but Mr. Gibson and Mrs. Onions still had doubts based on Dr. Nanayakarra. Their receipt of his letter (a week late, for some unknown reason), which noted the spate of emergencies, "removed" this doubt (AR 4.18.8), and Mr Gibson phoned the police on the morning of 30.4.91.

The storyline constructed by the inquiry team depicts the medical staff as noting each individual event, while failing "to recognize the emerging pattern" (AR 4.1.5). Abstracting from the details provided on the attacks by the Report, the general pattern the inquiry team thought should have been evident was something like this:

1. Allitt is left alone with a child
2. Allitt reports unusual symptoms relating to the child
3. Other staff respond to Allitt's alarm
4. The child is found to have collapsed
5. The collapse is diagnosed as "unusual" by the doctors
6. The child dies or is transferred to another hospital
where he or she recovers

As a matter of fact, however, this pattern was only detected after a lengthy police investigation.

One aspect of the pattern, i.e. the sudden incidence in unexpected child collapses, was noted as early as 30.3.91 by Dr. Porter and more generally by nursing staff by 7.4.91. This "noticing" of unusual incidents is constituted by the Report as a sort of incipient rather than actual pattern recognition: even at a very late stage, it seems, many people thought that rather than a pattern there might be a random cluster resulting from sheer misfortune or lack of resources.

The important question for us is the extent to which we find this narrative plausible. Expressed another way, the question is to what extent the account is consonant with current theories of sensemaking in organizations. As a matter of fact, the Report's description of individuals who observe events, notice unusual occurrences, but fail to discern a pattern, resonates with what we know of peoples' sensemaking proclivities. Current theories suggest that in order to discern a pattern "people chop moments out of continuous flows and extract cues from those moments" (Weick, 1995, p.43). The action to extract cues is conducted under the influence of "arousal" (Berscheid, 1983; Mandler, 1984), and arousal is prompted by a stimulus in the form of an interruption of expectations (Fiske & Taylor, 1991, p.265-266; Louis & Sutton, 1991). Not all unusual or unexpected events will stimulate arousal and search behaviour. Indeed, it is only occasionally that what is noted to be "novel" is consequential in this way. When an interruption occurs, whether sensemaking takes place will depend on factors such as (1) how habituated action is, and (2) the severity of the interruption (Schroeder *et.al.*, 1989, p.123; Weick, 1995, p.101). In those instances where action is highly prescribed by habituation, and the interruption is insufficiently shocking to stimulate people's action thresholds, then complex perceptual processes will tend to assimilate whatever is seen to whatever is expected (Bruner, 1986; Weick, 1995). This is because plausibility and coherence, rather than accuracy, are the principal drivers of sensemaking. In those instances where significance is attributed to an interruption, perhaps because of the anxiety provoked by the resulting uncertainty, search behaviour (for a pattern) may then ensue. The attribution of significance to an interruption requires people to define it as warranting a place on their agenda, which they often do by labelling it as an actual or potential problem, thus indicating that to an extent what constitutes an "interruption" is itself an invention rather than a discovery, "an attention allocation device" (Smith, 1988, p.1491).

The initiation of pattern search behaviour is no guarantee of pattern recognition. If arousal is

relatively weak, and the pattern complex and difficult to discern, then the search for a pattern may be prematurely concluded. Alternatively, if an interruption leads to pattern search behaviour before an identifiable pattern has emerged, then not only will the search behaviour be frustrated on this occasion, but future similar-type interruptions may not subsequently lead to highly motivated search as a result of a mistaken belief that there is no pattern to be found. This may help explain the sensemaking activities of Dr. Nanayakarra, who puzzled over the first two deaths, was able to discern no connection between them, and then virtually ignored the possibility that subsequent collapses might be in some way connected. In short, he may have filtered out those stimuli which he subconsciously recognized would "detract from an energetic, confident, motivated response" (Weick, 1995, p.60).

Another possibility is that the pattern search activities of professionals will be strongly guided, and restricted, by the training and socialization to which they have been subjected (Brim, 1966; Van Maanen & Schein, 1979; Whyte, 1956). It is, for example, noticeable that the doctors conscientiously sought to account (give a medical explanation) for each individual collapse. Yet because there was little similarity in terms of the symptoms each child exhibited, usual medical explanations linking the collapses (such as infection) were not available. There was also some variation within the general pattern of the attacks: for example, Michael Davidson recovered while at GKGH, Becky Philips died having been discharged, and Allitt seems to have employed a variety of different methods of attack, including injection with insulin and potassium, and suffocation. In such circumstances, the micro-focus of the doctors and nurses might, to an extent, reflect a training regimen which dictated that they should concentrate on finding plausible individual patient-centred explanations. It is, in addition, a highly pragmatic response which supports the well attested finding that people "see and find sensible those things they can do something about" (Weick, 1995, p.60). Nothing could now be done by the doctors for those patients who had died or been transferred to other hospitals, and this lack of capacity for action may have circumscribed their pattern search behaviour.

It is, of course, not just socialization procedures but a whole host of factors such as institutional context, and the number and diversity of tasks being engaged in by potential sensemakers which consume memory space and time for mental processing, that will affect which cues are extracted

from events and how they are then used to develop a larger sense of what is going on (Salancik & Pfeffer, 1978, p.233). In this case we would do well to recall that these events occurred in a hospital setting, and that reports of murder of child patients were virtually unprecedented (AR 5.4.2, AR 5.4.9). Moreover, Ward Four had an average of twelve patients at any one time during the first four months of 1991, and given the low staffing levels, the clinicians were extremely busy in a high load, high complexity and high turbulence information environment (Huber & Daft, 1987). In these circumstances, while each collapse constituted an interruption which produced arousal in the doctors, only a small number of cues were attended to in each case. Indeed, the frequency of the interruptions, rather than aiding pattern recognition, may have led to further cognitive inefficiency by raising arousal levels to the point where increasingly few cues were extracted and processed (Easterbrook, 1959; Wachtel, 1967).

In order to discern patterns in organizational activities, participants find it helps if the flow of events is punctuated by, for example, product launches and off-site strategy meetings which "focus and crystallize meanings" by serving "as focal points for the different streams of ongoing activity in the organization" (Eccles & Nohria, 1992, p.48). Dr. Porter's attendance at the Annual Conference of the British Paediatric Association on 16.4.91 seems to have constituted such a punctuation point, for three days later he had come to the conclusion that there was a pattern to recent events that implied someone was deliberately harming patients on Ward Four. That the conference did not lead Dr. Nanayakkara, who attended on 17.4.91, to a similar conclusion, might be accounted for in terms of their different prior experiences of events (as noted, Dr. Nanayakkara seems to have discarded the possibility of the collapses being linked at an early stage), and general perceptiveness and pattern-recognition capabilities. It is interesting to note that Dr. Porter was described as both having a reputation for fanciful ideas (AR 4.16.5) and as being a bit unpredictable (AR 4.16.9), and that these descriptions might very well symptomize an individual with an institutional history of being more adept than his colleagues at detecting patterns in events.

Two important and related questions that the Report provides answers to are: (1) when did any form of pattern recognition occur? and (2) what forms did this pattern recognition take? "Pattern" is here understood to refer to a series of events which are either directly linked or

which form a distinct class or set, i.e. occurrences which have at least one salient factor in common. The Report suggests that Dr. Porter was aware of an incidence of unexpected child collapses by 30.3.91, and that many doctors and nurses had noted this by 7.4.91, at which time there was talk about the possibility of infection. The notion that the collapses were linked (i.e. their common cause was infection) was not followed-up, indicating that this incipient pattern recognition was never actualized. By 19.4.91 Dr. Porter had clearly recognized that the child collapses most likely had a common cause (a malicious individual), i.e. formed a pattern. Dr. Nanayakkara (on 22.4.91), Mrs. Onions (on 24.4.91) and the Night Services Manager (on 31.3.91) all recognized that the collapses were "unexpected", i.e. there was general pattern recognition, but a failure to recognize the pattern as intensely problematic. By 29.4.91 Dr. Hull at QMC recognized a pattern of unexpected child collapses, and the possibility that they had been caused by a malevolent individual. The following day, Mr. Gibson and Mrs. Onions appear to have been able to perceive a possible pattern of unexpected child collapses that merited police investigation.

For many staff on Ward Four the tentative recognition of a possible pattern of collapse was accompanied by "standard" or "conventional" explanations which identified them as constituting a distinct category, i.e. as caused either by infection or a lack of resources. That people who perceive ambiguity in events tend to rely on routine and traditional interpretations of them is a consistent research finding (Levine, 1985, p.8; Isabella, 1990, p.17; Martin, 1992, p.134; March, 1994, p.178; Weick, 1995, p.92). Indeed, the very idea of "sensemaking", it seems, implies the editing of continuity "to render the world less unique, more typical, more repetitive, more stable, more enduring" (Weick, 1995, p.108). The reliance on a relatively small number of standard frames which enable people to categorize, locate and label data (Snow, et. al., 1986, p.464; Starbuck & Milliken, 1988, p.51) is indicative of our satisficing tendencies. Sensemaking heuristics which favour expediency and pragmatism in the face of the huge costs that may be involved in searching for non-standard explanations appear often to be highly functional (Turner, 1971; Czarniawska-Joerges, 1992). In this instance, however, the standard explanations drew on the culture (Schein, 1985) or ideology (Trice & Beyer, 1993, p.33) of the medical profession, and this incorporated implicit premise controls (Perrow, 1986) which caused individuals to downplay "deliberate harm" as an explanatory category, resulting in a "professional blindspot" (Weick,

1995, p.113).

Perhaps what was required in order to crystallize a pattern in peoples' minds was agreement on an appropriate word or label that could have helped forge a consensus of understanding. As Weick (1995, p.106) has noted, "Sense is generated by words that are combined into sentences of conversation to convey something about our ongoing experience" (see also Pfeffer, 1981). As a matter of fact people are represented by the Report as being highly resistant to employing terms such as "murder" and "murderer" (AR 4.11.5) despite what might be regarded as *prima facie* evidence available at the time. For example, Allitt's "colleagues did note that she was invariably present when a child collapsed, but they failed to attach any significance to the fact. Indeed, some of them teased her as an agent of bad luck" (AR 5.8.16). In addition, no one worried over the fact that on at least four occasions the alarms attached to the childrens' monitoring equipment failed to sound, probably because Allitt had turned them off, (AR 5.11.5) or saw fit to query "the remarkable similarities in her [Allitt's] descriptions of several of the various episodes when children collapsed" (AR 5.10.18). The actions of individuals following the discovery that Paul Crampton's blood contained exogenous insulin are again instructive. Rather than directly confront the possibility that he had been deliberately injected, staff put their efforts into investigating whether he had been harmed accidentally. What is more, having informed Dr. Porter that accidental administration of insulin was not a possibility on 18.4.91, Mrs. Onions and Mrs. Barker felt compelled to continue to check this hypothesis up until the time that the police were called. Short of actually witnessing Allitt in the act of harming a child, it seems, the social sanctions which prohibited individual or social reference to the possibility of murder, meant that almost any other explanatory category was more available for making sense of events.

In the modal sensemaking case, people extract cues which prophesy the nature of events, and this permits them to act confidently in particular ways. In the course of action the prophesy and the event are mutually "informed by and adjusted to the emerging picture of the other" (Weick, 1995, p.54). There are, however, extreme cases, where this normal sensemaking breaks down. When this happens at an individual level, there is no guarantee that a different course of action will then be pursued by that person. The point is that sensemaking is a social process that requires agreement on relevant considerations, and the sharing of mutually acceptable

interpretations (Burns & Stalker, 1961, p.118; Allport, 1985). If others do not share an individual's understanding of events and fail to act in accord with his/her views, then his/her sensemaking may lack substance, that is, retain an air of unreality (Weick, 1983, p.228-230). What is more, these conflicts in accounts, sometimes called "reality disjunctures" (Gephart, 1984, p.213), are highly threatening for the individuals concerned because they suggest that one cannot see the world correctly (Pollner, 1975). This might be a partial explanation for Dr. Porter's inaction between 18.4.91 and 29.4.91, despite his recognition of a pattern indicating foul play. Dr. Porter, it appears, felt that he had to fit his "own line of activity in some manner to the actions of others" (Blumer, 1969, p.8) who were more successful than he in arguing for their own definition of events (Cohen, March & Olsen, 1972, p.25; Tompkins, 1987; Anderson, 1983).

Also significant in this regard may be the infrequency of meetings between key staff at GKGH. Meetings, it has been observed, both allow sense to be made and negotiated (they are "the infrastructure that creates sense" (Weick, 1995, p.144)), and represent opportunities in which problems and solutions are combined (Cohen, March & Olsen, 1972). Relatively few meetings of three or more people meant that information was not adequately shared, understandings were partial, arguments were flawed, and the scope for action restricted. As the Report noted, "Virtually all the staff appear to have discussed what was happening with others informally at one time or another. Each had their own ideas, but there was no forum in which they could work through the possibilities systematically" (AR 5.10.3). Furthermore, the two consultants, who might have been expected to discuss events with each other on a regular basis, both pursued their "own line of enquiry with inadequate reference to the other" (AR 5.10.8). Actualization rituals in which hunches and suspicions could be transformed into social facts and actioned were thus minimal. Indeed, it took a meeting of doctors at QMC rather than GKGH, a meeting at which only five child collapses were discussed, for progress to be made. It was not until Dr. Porter's sensemaking was reinforced by Sir David Hull's confirmatory opinion that he took decisive action, and it was not until Mr. Gibson received Dr. Nanayakkara's letter which clearly spelled out that there had been a recent spate of child collapses that he felt able to contact the police.

It is evident that the *Allitt Report* is susceptible to interpretation using organizationally-based theories of sensemaking. That is, the actions and events described in the Report confirm more

than they contradict accepted views of how and why people read meaning into social situations. This is an important if not unexpected finding. Without such consonance we would be faced with the choice of criticizing the *Allitt Report* as unauthoritative, or our theories of sensemaking as implausible. It is important to note that it is a perception of congruence, and not precise correspondence between theory and narrative, that is required here in order for the Report to successfully elicit a verisimilitude attribution and extend its hegemonic allocation of blame and absolution.

Blaming and Absolving

The attempt to normalize Allitt's apparent personality, and the description of how individuals came to discern and problematize a pattern of events, provide a narrative framework which allows the Report to attribute culpability "where [the inquiry team feel] it belongs" (AR, p.131). A large number of specific critical and absolving statements appear throughout the Report, blended with detailed descriptions of the events themselves. Retrospective reconstruction (description) of events and judgemental commentary are thus integrated and mutually reinforcing: a rhetorical strategy that permits a more authoritative distribution of blame and absolution, with a heavy emphasis on the latter. In broad terms, the normalization of Allitt's manifest personality makes the actors' failure to discern a pattern verisimilitudinous, and this in turn invites exoneration rather than blame.

The Report employs four general absolving strategies. Foremost among the arguments for general absolution was, as we have already seen, that Allitt appeared to be a "normal" person. In short, that she possessed no characteristics that were "clear indicators of possible danger" (AR 2.1.4), and that there were therefore no personality-related grounds for excluding her from the nursing profession or for suspecting her involvement in events on Ward Four. Second, the Report argues that while in retrospect what was going on, and Allitt's involvement, now seem palpable, at the time these facts "must have been mere shadows in a fog of bewilderment to those grappling with events" (AR 1.10), i.e. that individuals should not be blamed for failing to recognize a complex pattern that only became fully evident after a lengthy police investigation. Third, the Report emphasizes that the events that occurred on Ward Four were unique in the UK, and "acknowledge[s] that it is difficult to imagine that someone in a hospital has attempted to

murder a child patient" (AR 4.11.5). That those involved did not consider this option seriously for so long is presented as reasonable given the inquiry team's own expressed view that "The idea of a nurse deliberately taking the lives of children under her charge is almost unthinkable" (AR 2.1.1). Finally, the Report notes that in the two other reported cases of nurses harming child patients they discovered, one in Canada and one in America, "the delays in detection were very much greater" than at GKGH (AR 7.2). In addition to these general statements of mitigation, the Report specifically absolves Allitt's School, Grantham College, Occupational Health Services at GKGH, and the local and regional health authorities from any and all blame.

The Report does, however, note a variety of instances where information was overlooked or misinterpreted and procedures were either not followed or inappropriately stipulated. For example, it criticizes the systems by which South Lincolnshire School of Nursing (SLSN) recruited Allitt from Grantham College, and the failure of Allitt's tutors at SLSN to formally refer her to Occupational Health given her numerous episodes of sickness. The Report is particularly critical of the way in which Allitt was recruited to Ward Four as an enrolled nurse, in which "virtually none of the procedures in the hospital's recruitment policy was followed" (AR 2.6.17). The major question in deciding issues of blame for the Report, though, was whether the police "could and should" have been called-in sooner than they were (AR 3.1.2), and here no unequivocal answer is provided. Instead, the Report merely catalogues a series of individual and institutional errors committed by actors both at GKGH and QMC.

Of the very first attack, on Liam Taylor, the Report makes it clear that if a paediatric specialist had conducted the post mortem, then "the first clue that there had been criminal activity might have emerged at this early stage" (AR 4.2.16). Indeed, when the police called in such a specialist "he concluded that the cause of death was administration of a noxious substance" (AR 4.2.15). The Report describe it as "disturbing" that Timothy Hardwick's death was attributed to "status epilepticus" when he evidently had not been having fits at the time (AR 3.3.3). In the case of Kayley Desmond x-rays taken at the time and showing that air had been injected into her were not examined by specialized paediatric radiologists (when it was "normal practice" that they should have been). The ward doctors instead "relied on their own judgment", and this evidence was consequently overlooked (AR 4.4.4). The case of Bradley Gibson (who was found to have

above the normal range of potassium in his blood) is described by the Report as so "extraordinary" that it "should have raised questions" (AR 4.6.3):

"This was the seventh unusual and unexpected episode of collapse of a child on Ward Four within a period of about four weeks....the cumulative effect on a thinking person ought to have been, in our judgment, to force a close and anxious scrutiny of all seven episodes. Matters had progressed beyond the bounds of reasonable expectation....No such decisive and commanding action was forthcoming.... But it might have [saved lives] and it should have been attempted" (AR 4.6.4; 4.6.6).

The symptoms of Yik Hung (Henry) Chan were consonant with a diagnosis of suffocation, were obviously not the result of febrile convulsions as diagnosed, and yet "still no firm or vigorous action was taken" (AR 4.7.2). In the case of Katie Philips not only did GKGH lose some x-ray films ("remov[ing] another potential piece of evidence" (AR 4.9.4)), but those that were available arguably showed evidence of healing rib fractures, though again these were not recognized at the time. When Michael Davidson collapsed the contents of the syringe were not retained for analysis as they should have been, and another "possible piece of evidence was lost" (AR 4.10.2). Having received the information regarding the level of insulin in Paul Crampton's blood the Report describes the GKGH staff as not acting decisively, and of taking days to rule out accidental injection "rather than the minutes one might expect" (AR 4.11.9). Finally, while Claire Peck's death was officially recorded as resulting from "status asthmaticus" this ignored two items of evidence that pointed to her death being suspicious: (she is now thought to have been injected with either potassium or lignocaine).

Rather than attempt to use their narrative to apportion blame to individuals, the inquiry team attribute what happened to "cumulative failures to act upon information which was there to be seen" (AR 4.19.3). Certain individuals are criticised for particular oversights, such as Dr. Porter's failure to act immediately after being informed regarding Paul Crampton's insulin level (AR 7.6.h), and Sister Barker for not taking "the lead in supervising the ward (AR 5.10.13). The idea that there was a general failure that was the shared responsibility of many people is, however, the dominant theme, and presented as part of a broader authorial strategy, the intent of which was to avoid creating "scapegoats" to "bear the guilt of disastrous happenings" (AR, p.131). A second, and never explicitly stated strategy, was to characterize this general failure as one of poor management rather than poor medicine. Thus the Report suggests that the "principal

failure" at GKGH was "a general lack of the qualities of leadership, energy and drive in all those most closely connected with the management of Ward Four" (AR 4.19.3; AR, p.131), and that where the consultants were at fault was in failing "to grasp with energy the problem presented by the highly unusual events that they were witnessing and to take systematic and decisive steps to elucidate their cause" (AR 4.19.4). Factors such as poor communication between the doctors, insufficient staffing levels, and poor procedures and practices are all implicated in the failure to detect Allitt earlier:

"...the failure was in lack of leadership and effective communication in a structure with no clear definitions of responsibility or accountability. Although a highly efficient and well-regulated organisation might still be vulnerable at the hands of a person like Allitt, the weaknesses that we have identified at nearly all levels of the GKGH administration provided poor protection against the unexpected" (AR 4.19.5).

That these failures are represented as general and managerial, rather than individual and medical, is significant. It is an interpretation of events that seeks to repair the legitimacy of the medical profession by refusing to blame individuals, by describing errors of medical judgement as procedural confusions, and by labelling "initiative" and "energy" managerial rather than medical issues (Pfeffer, 1981; Suchman, 1995). Indeed, rather than criticize the consultants for practising poor medicine, the Report explicitly commends "the two Consultant Paediatricians for their skill and dedication" (AR 7.6). The Report is thus interpretable as an insidious exercise in power which seeks to engineer a definition of "reality" (i.e. what really happened) to obfuscate and mystify real interests, and to present actions as normatively acceptable (Lukes, 1974; Wuthnow, *et. al.*, 1984; Knights & Willmott, 1985).

DISCUSSION AND CONCLUSIONS

This paper started by asking what we could learn about sensemaking from the reports authored by inquiry teams. Inquiry reports were highlighted as potentially insightful given an understanding of sensemaking as a narrative process. The analysis of the *Allitt Report* offered suggested that inquiries construct narratives designed to strike their target audience as plausible and authoritative, i.e. verisimilitudinous. In order to achieve this they must accord with prevailing notions regarding what constitutes a reasonable depiction of human social behaviour.

In short, inquiry reports are contrived rhetorical products that contain an implicit argument in support of their own veracity, and which stifle potentially competing or contradictory storylines.

Concomitantly, our theories of sensemaking also tend to conform more than they contradict the same general macro-social conventions regarding the adequacy of descriptions of social action. The consequence is that generally acceptable inquiry report narratives tend to be susceptible to analyses in terms of prevailing theories of sensemaking. A disjuncture between the two would mean either (1) that the Report would be ineffective as an exercise in power, or (2) that the theory applied to it was not credible. Given the importance of inquiry reports in legitimating social institutions, ameliorating the anxieties raised by the critical events investigated, and their subsequent intended use as sensitizing archetypes, their authors tend to ensure that palpably implausible reports are re-drafted. Similarly, the vested interests which support scholarly theorizing in the field of sensemaking usually guarantee a minimum of counter-intuitive and counter-conventional theory. Consonance is thus virtually assured. The issues raised by this analysis, which centre on concepts of rhetoric, power, anxiety-reduction, and narrative archetype, merit further brief attention.

The Report of the Inquiry is appropriately regarded as a rhetorical construct, an artifact created to persuade us to accept a (non-irrefragable) interpretation of events. This point is important because it reminds us that inquiry sensemaking involves the deployment of arguments the intent of which are to influence others. The notion that as a minimum requirement a text must contain an implicit argument regarding its own plausibility, and that authors of texts are engaged in a process of rhetorical persuasion, is well attested (Nelson, Megill, & McCloskey, 1987:3; see also Edmondson, 1984; McCloskey, 1985; Watson, 1994). While there has not yet been a "consolidated effort at rhetorical analysis in organization studies" (Czarniawska-Joerges, 1995: 148), there is evidence of a growing recognition of the pervasiveness and importance of rhetoric as a focus for research (Bartunek, 1994; Edmondson, 1983; Gusfield, 1981; Jeffcutt, 1994; Thompson, 1991; Van Maanen, 1988; Yates and Orlikowski, 1992). The role of rhetoric in the representation of ethnographic data has, however, been widely discussed among anthropologists (Conkling, 1975; Geertz, 1988; Marcus & Cushman, 1982; Pratt, 1986; Sanjek, 1990; Wagley, 1983). What this paper has illustrated is the centrality of rhetorical concerns to

the products of inquiry sensemaking, i.e. how acts, agents, scenes, and intentions are employed to manipulate both our understandings and emotional responses.

Public inquiry sensemaking as encoded in their rhetorical products (reports), is an exercise in power. As with orally transmitted narratives, organizational and institutional texts inevitably serve hegemonic and legitimation functions (Boje, 1995; Boyce, 1996; Martin, *et. al.*, 1983). The *Allitt Report* is a monologue, a univocal representation that omits, marginalizes, and selectively highlights in its suppression of interpretive plurality (Barry & Elmes, 1997; Brown, 1998). To the extent that it blames individuals it is for failing in their organizational rather than their medical roles, that is, for lacking in terms of leadership, for communication breakdowns, and for procedural slackness. To the extent that it blames GKGH it is for being poorly organized, for inappropriate management structures, and for low staffing levels, rather than for providing questionable standards of care. The artificial distinction between medical and organizational failings is key to the Report's attempts to maintain the credibility of the medical profession, and strikingly plausible in a UK context because of an institutionalized separation between medical and managerial roles that has proved ideologically seductive (Foucault, 1977; Trice & Beyer, 1993). As Kemp (1985: 177), commenting on public inquiries generally, has stated, their outcomes "are rarely objective, rational, and egalitarian; they are manipulated to further...[certain]...interests...[and]...a primary mechanism through which this is achieved is the systematic distortion of the communication process..." (see also Gephart, 1984, 1990; Gehart, Steier & Lawrence, 1990).

The *Allitt Report* served to reduce the general anxiety that had been excited by the successful prosecution of Allitt. The prevalence of the threat of anxiety to organizational participants who are constantly seeking to maintain a sense of self-esteem, and to project order and stability onto their workplace has been widely observed (Zaleznik, 1966; Berger, 1973; Schweiger & Denisi, 1991; Watson, 1994). Allitt's actions, we may speculate, were extremely anxiety-provoking for at least two reasons: first, they suggested to the medical profession and the general public that hospitals were not wholly safe and medical staff not necessarily benign; second, they threatened participants rationalistic models for understanding organizations. The Report, (like all inquiry reports), ameliorated anxiety by rendering events apparently more comprehensible (by

purporting to explain how and why things happened the way they did), thus increasing feelings of control over the present and future among significant stakeholder groups. It was, perhaps, Allitt's threat to societally predicated "assumptions of control" (Turner, 1978: 7) that was most anxiety-provoking of all, revealing as they did "the unpredictability of human behaviour" (Knights & Willmott, 1985: 25) which renders organizations "in a very literal sense out of our, or indeed anyone's control" (MacIntyre, 1981: 101). Inquiries might usefully be thought of as cathartic ceremonies and the reports they produce as public discourse myths, which help modern societies cope with mysterious events and broker anxiety by enticing us to engage in fantasies of control (Boje, Fedor & Rowland, 1982; Bormann, 1983; Gusfield, 1981).

Inquiries into unusual and unexpected occurrences produce reports which serve as sensitizing narrative archetypes. The *Allitt Report* is a particularly good example of this, encoding as it does a storyline unique in the UK. The point is that now the possibility of nurse attacks on children has been recognized, exemplified, and commented upon, this should make this sort of explanatory narrative more available to people trying to make sense of similar-type unexpected events in the future. One of the functions of inquiry sensemaking is, thus, to produce relatively novel plotlines that link events and provide explanations in ways previously only inchoately recognized. This value of their Report was in fact recognized by the *Allitt Inquiry* team who incorporated it into their final recommendation: "The main lesson from our Inquiry and our principal recommendation is that the Grantham disaster should serve to heighten awareness in all those caring for children of the possibility of malevolent intervention as a cause of unexplained clinical events" (AR: 130). Inquiry reports thus make an important contribution to the "conversational and social practices ...through which the members of a society socially construct a sense of shared meanings for that society and its institutions" (Gephart, 1993: 1469; Berger & Luckmann, 1966; Garfinkel, 1967).

In conclusion, no single case study is without significant limitations, and in this instance it is worth noting that the *Allitt Report* doubtless embodies and reflects the ideological and institutional idiosyncracies of the UK cultural context. It should also be observed that the interpretation of the text of the Report provided here is itself contestable, though hopefully one which is also interesting, plausible, and informative. In framing an analysis based on the product

of an inquiry's sensemaking efforts this paper has sought to both problematize an interesting yet relatively ignored phenomenon, and draw attention to the very great extent to which sensemaking is a narrative process. Most importantly of all, it has suggested that while sensemaking in organizations is normally focused on authoring the self and maintaining self-esteem, inquiry sensemaking is more concerned with authoring an artful and verisimilitudinous account with broad social implications: it is an exercise in power that extends control, blames, absolves, and legitimates.

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